DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/19/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445108	A. BUILDING _____ B. WING _____	09/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NHC HEALTHCARE, MURFREESBORO	420 N UNIVERSITY ST MURFREESBORO, TN 37130

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An annual recertification survey and complaint investigations #26984, 27159, 27944, 27781, 28011, 28201, and 28402, were completed on September 12-14, 2011, at NHC Healthcare of Murfreesboro. No deficiencies were cited related to the complaint investigations under CFR Part 483, Requirements for Long Term Care Facilites.	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to provide incontinence care timely respecting the dignity of one (#12) of twenty-six residents reviewed. The findings included: Resident #12 was re-admitted to the facility on September 2, 2011, with diagnoses including Peg Tube placement and Stage 4 Chronic Kidney Disease. Medical record review of the Minimum Data Set dated August 12, 2011, revealed the resident required assistance with all activities of daily living. Observation and interview on September 14, 2011, at 8:18 a.m., in the resident's room,	F 241	F 241 Resident #12 received a hot meal and had her personal hygiene needs tended to on 9/14/2011 at 8:45 AM. CNA # 1 was in-serviced on 9/21/11 by the Rehab Nurse Manager on promptness of service and accommodation of patient needs. All CNA's will be in-serviced on promptness of service and accommodation of needs by 10/10/2011 by the Nurse Managers. A QA study on promptness of service will be conducted by the DON or The Nurse Manager by observation and interview of patients to ensure patients needs are being meet monthly times 3. This will be presented to the QA Committee. The QA committee consistent of the Administrator, DON, HIM, Medical Director, Social Worker, Dietitian and Doctors. The QA committee will review and make any recommendations for improvement.	10/10/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lynn Foster	Administrator	9/30/11

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

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F 241	Continued From page 1 revealed the resident in bed, the resident's breakfast tray on the over bed table, with none of the containers opened. Interview with resident #12 revealed the resident did not want the food tray set up because the resident was waiting for staff to return to the room and cleanup the resident "I have a dirty diaper, they said they would get help and be right back to clean me up, but no one has come back" Observation on September 14, 2011, from 8:20 a.m. to 8:45 a.m., (25 minutes) at the rehab nurse's desk observing the resident's doorway, revealed three Certified Nurse Assistants (CNA) and four nurse's passed the resident's door and none of the staff entered the room to assist the resident Interview on September 14, 2011, at 8:45 a.m., with CNA #4 at the rehab nurse's desk revealed CNA #1 had delivered resident #12's breakfast tray to the room. Observation on September 14, 2011, at 8:47 a.m., revealed CNA #2 and CNA #3 entered resident #12's room and provided incontinence care for liquid feces. Continued observation revealed CNA #4 went to the facility kitchen and got a hot breakfast tray for the resident. Interview on September 14, 2011, at 9:05 a.m., with resident #12 with CNA #2 and CNA #3 present in the resident's room, "...I waited over an hour for help, they said they would be right back, I watched the clock, this is too long to wait!..." Interview on September 14, 2011, at 10:44 a.m., near room 162 with CNA #1 confirmed CNA #1	F 241		

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F 241	Continued From page 2 delivered resident #12's breakfast tray that morning and the resident had requested assistance with incontinence care due to having liquid feces. Continued interview revealed CNA #1 looked for another staff member to assist cleaning up the resident but no one was in the hallway and the CNA continued to deliver breakfast trays. Continued interview confirmed the resident waited for 25-60 minutes for staff to return when the resident was soiled with feces did not respect the resident's dignity.	F 241		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by:	F 279		

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F 279	Continued From page 3 Based on medical record review, observation, and interview the facility failed to update the care plan for two residents (#1, #17) of twenty-six residents reviewed. The findings included: Resident # 1 was admitted to the facility on August 9, 2010, with diagnoses including Dementia and Congestive Heart Failure. Medical record review of the resident care plan revised July 5, 2011, revealed "...Problem...overall decline in condition...Approaches...tilt back wheelchair for positioning. Continued medical record review of the current care plan dated July 20, 2011, revealed no documentation of the positioning devise. Interview with the Minimum Data Set Coordinator (MDS) #1 on September 13, 2011, at 10:30 a.m., at the west wing nurse's station, confirmed the facility failed to revise the care plan to address the positioning device. Resident #17 was admitted to the facility on June 30, 2011, with diagnoses including Open Wound of the Anterior Abdomen Wall, Multiple Myeloma, Diabetes, Hypertension, and End Stage Renal Disease. Medical record review of the MDS (Minimum Data Set) dated August 21, 2011, revealed the resident scored 15 of 15 on the BIMS (brief interview for mental status), and received hemodialysis. Interview with the resident on September 13,	F 279	F279 Resident # 1 had her care plan updated to reflect the use of a tilt back wheelchair and/or rock-n-go wheel chair on 9/14/2011. Resident # 17 had her care plan updated on 9/14/2011 to reflect the actual vas-cath device. All patients in tilt back wheel chairs and rock-n-go's will have their care plans reviewed and updated as needed by the Nurse Manager By 10/1/11. All patients receiving dialysis will have their care plans reviewed and updated by the Nurse Manager to reflect specific types of catheters in use by 10/1/11. A Q A study of the care plans will be conducted monthly by the DON or nurse manager for 3 months. The QA study will be done by chart audits and review of patient devices. The QA study will be presented to the QA committee. The QA committee consistent of the Administrator, DON, Medical Director, HIM, Social Services, Dietitian, and Doctors. The QA committee will review and make recommendations for improvement.	10/1/11

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F 279	Continued From page 4 2011, at 3:40 p.m., in the resident's room, revealed the resident received dialysis at a local clinic three days per week. Continued interview revealed the resident received treatment via a subclavian catheter located in the right chest area. Medical record review of the care plan updated August 14, 2011, did not reflect the subclavian catheter, including the type of care or precautions. Interview with the Director of Nursing (DON) on September 14, 2011, at 8:00 a.m., in the DON's office, confirmed the care plan did not address the resident's subclavian catheter for dialysis.	F 279		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review and observation the facility failed to ensure communication with The End Stage Renal Dialysis Clinic (ESRD) for one resident (#17) of twenty-six residents reviewed. The findings included:	F 309		

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F 309	Continued From page 5 Resident #17 was admitted to the facility on June 30, 2011, with diagnoses including Open Wound of the Anterior Abdomen Wall, Multiple Myeloma, Diabetes, Hypertension, and End Stage Renal Disease. Medical record review of the Minimum Data Set dated August 21, 2011, revealed the resident scored 15 of 15 on the BIMS (brief interview for mental status), and received hemodialysis. Interview with the resident on September 13, 2011, at 3:40 p.m., in the resident's room, revealed the resident received dialysis at a local clinic three days per week. Continued interview revealed the resident received hemodialysis treatment via a subclavian catheter located in the right chest area. Medical record review revealed no documentaion of any communication with or from the dialysis clinic on the care or precautions of the subclavian catheter. Interview with the Director of Nursing on September 14, 2011, at 8:00 a.m., at the nurses' station, confirmed the medical record contained no documentation of communication with the dialysis clinic regarding the subclavian catheter.	F 309	**F309** Resident # 17 had information from the dialysis center obtained on 9/14/11. All patients with dialysis had information obtained from the dialysis center by 9/26/11. A dialysis communication tool was developed and the DON spoke to all dialysis centers on its use on 9/20/11. All licensed nurses will be in-serviced by the Nurse Managers on the new tool by 10/10/11. A QA study on the use of the tool will be conducted by the DON or Nurse Manager monthly for 3 months. The QA will conducted by chart audits. The QA study will be presented to the QA committee which consist of the Administrator, DON, HIM, Medical Director, Social Worker, Dietitian and Doctors. The Committee will review and make any recommendations for improvement.	10/10/11
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident	F 315		

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F 315	Continued From page 6 who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to provide incontinence care correctly to prevent urinary tract infections for one (#12) of twenty-six residents reviewed. The findings included: Resident #12 was re-admitted to the facility on September 2, 2011, with diagnoses including Peg Tube placement and Stage 4 Chronic Kidney Disease. Medical record review of the Minimum Data Set dated August 12, 2011, revealed the resident required assistance with all activities of daily living. Observation on September 12, 2011, at 8:50 a.m., in resident #12's room revealed Certified Nurse Assistant (CNA) #2 and CNA #3 assisted the resident with incontinence care for liquid feces and indwelling urinary catheter care. Continued observation revealed while the resident laid on the back, CNA #2 held the resident's indwelling urinary catheter drainage bag approximately ten to twelve inches above the resident (allows the urine to run back into the bladder), while CNA #3 used a wet towel to wipe the liquid feces from the resident's inner thighs.	F 315	**F315** Resident # 12 had catheter and perineal care performed following the procedure after the issues was brought to the unit mangers attention. CNA's # 2 and # 3 were in-serviced on catheter and perineal care on 9/21/11by the nurse manager. All CNA's will be in-serviced by the nurse managers by 10/10/11 on catheter care and perineal care. A QA study on catheter care and perineal care will be conducted by the DON and/or the nurse manager by observation monthly for 3 months. The QA will be presented to the QA committee which consist of the Administrator, DON, HIM, Medical Director, Social Worker, Dietitian and Doctors. The QA committee will review and make recommendations for improvement.	10/10/11

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F 315	Continued From page 7 Continued observation revealed after the resident was assisted to lie on the right side CNA #2 using a disposable wipe, washed from the resident's anus to the perineum (area between the vagina and the anus) to remove the liquid feces; while CNA #3 held the resident's indwelling urinary catheter drainage bag approximately twelve inches above the resident. Continued observation revealed as CNA #2 assisted the resident to a comfortable position CNA #3 held the resident's indwelling urinary catheter drainage bag approximately twelve inches above the resident. Interview on September 14, 2011, at 9:10 a.m., at the rehab nurse's desk with Unit Manager #1 confirmed washing from a resident's anus towards the perineum and holding an indwelling urinary catheter drainage bag above the resident could cause a urinary tract infection and was not the correct procedure to complete incontinence care.	F 315		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced	F 371		

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F 371	Continued From page 8 by: Based on observation and interview, the facility dietary department failed to maintain equipment in a sanitary manner and failed to remove an expired food product. The findings included: Observation on September 12, 2011, beginning at 10:00 a.m., with the Registered Dietitian present, revealed the following: 1.) Numerous one-half steam table pans and one-third steam table pans were stacked and stored wet on the storage rack. 2.) The underside of the muffin tins had a heavy accumulation of blackened debris. 3.) The mid-sized table top mixer had dried white and tan splatters on the underside of the beater arm. 4.) The six burner range top back splash and spill pan had a heavy accumulation of blackened debris. 5.) The can opener had metal shavings present on the base of the can opener. Observation on September 12, 2011, beginning at 10:18 a.m., with the Registered Dietitian and Dietary Manager present, revealed the following: 1.) In the walk-in refrigerator was a container labeled Pimiento Cheese dated "9/3" (September 3). Interview with the Registered Dietitian on September 12, 2011, present during the observations beginning at 10:00 a.m., in the dietary department, confirmed the pans on the	F 371	F371 NHC Murfreesboro does maintain the dietary Department in a clean and sanitary manner. All pans of various sizes were checked for wet nesting and pulled from shelves and re-washed immediately. New muffin pans were ordered to replace old pans with black debris. The table mixer was cleaned immediately. The six burner range top back splash and spill pan was cleaned to remove the blackened debris. The can opener blade and gear was replaced. The pimento cheese was discarded of and all items in the refrigerator were checked for appropriate dates. The entire kitchen was inspected for cleanliness on 9/14/11by the Dietary Manager. Staff was in-serviced by the Dietary Manager on proper cleaning and appropriate dates for new labels for opened food in refrigerator. In-service will be conducted on 9/28/11 to all dietary staff. The dietician will conduct a QA study on wet nesting, sanitation and proper storage of opened food by using the Food Safety and Sanitation Checklist monthly x3 months. This will be presented to the QA committee which consist of the Administrator, DON, Medical Director, HIM, Social Worker, Dietitian, & Doctors. The QA committee will review and make any recommendations.	9/28/11

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F 371	Continued From page 9 rack were stacked and stored wet. Further interview confirmed the underside of the muffin tins had blackened debris present. Further interview confirmed the mixer had not been used since last night and the underside of the beater arm had dried tan and white splatters present. Further interview confirmed the range top back splash and spill pan had an accumulation of blackened debris. Further interview confirmed the can opener had metal shavings present. Continued interview confirmed the pimiento cheese "was out of date" and was to have been discarded.	F 371		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a	F 441		

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F 441	Continued From page 10 communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, facility policy review, and interview, the facility failed to follow the facility's policy for Infection Control for two residents (# 2, #20) with clostridium difficile of twenty-six residents reviewed. The findings included: Resident # 2 was admitted to the facility on February 4, 2011, with diagnoses including Alzheimer's Disease, Dementia, and Anxiety State. Medical record review of a laboratory result dated August 30, 2011, revealed "...C (clostridium) Difficile (bacterium that causes diarrhea) positive..." Resident # 20 was admitted to the facility on June 16, 2011, with diagnoses including Congestive	F 441	**F441** The red bag that was identified on the floor in resident #2 and #20 room was removed immediately and the contents disposed of properly. All isolation rooms were checked for red bags not in containers by the Nurse managers. An in-service will be conducted by the Nurse Managers for the staff by 10/10/11. A QA study of proper placement of biohazard bags by room observation will be conducted by the DON or Nurse Manager monthly for 3 months. The QA will be presented to the QA committee which consists of the Administrator, DON, HIM, Medical, Social Worker, Dietitian, and Doctors. The QA committee will review and make any recommendations for improvement.	10/10/11

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NHC HEALTHCARE, MURFREESBORO	420 N UNIVERSITY ST MURFREESBORO, TN 37130

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 11 Heart Failure, Anemia, and Chronic Kidney Disease. Medical record review of a laboratory result dated August 24, 2011, revealed "...C (clostridium) Difficile positive..." Observation of resident #2, and #20 (roomates) in the residents room on September 13, 2011, at 8:02 a.m., revealed both residents were in contact isolation. Continued observation of the resident's room at this time revealed a red biohazard bag partially filled with linens, in the floor in front of resident # 2's bed, not in a container. Review of the facility's policy for " Clostridium Difficile Guidelines" revealed "...contact isolation:...all trash and linen containers will be lined with red biohazard bags..." Observation and interview with the unit manager #2 on September 13, 2011, at 8:12 a.m., in the resident's room confirmed the red biohazard bag should be placed in a container. Interview with the Director of Nursing on September 13, 2011, at 8:15 a.m., at the west unit nurse's desk confirmed that the facility's failed to maintain infection control for residents with clostridium difficle.	F 441		
F 456 SS=D	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.	F 456		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 456	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on observation and Interview, the facility failed to maintain the tilt skillet in the dietary department and failed to maintain the temperature control mechanism for one of three steam tables observed. The findings included; Observation on September 12, 2011, at 10:17 a.m., in the dietary department with the dietary manager present, revealed a missing vent cover on the lid of the tilt skillet. Further observation revealed the tilt skillet was in use at the time of the observation. Interview with the dietary manager on September 12, 2011, at 10:17 a.m. in the dietary department, confirmed the skillet vent was to be covered. Observation on September 13, 2011 at 8:09 a.m., of the two west dining room tray line in operation, with the dietary manager present, revealed the temperature control knobs on the right hand side of the steam table were missing. Interview with the dietary manager at 8:25 a.m., on September 13, 2011, in the two west dining room, confirmed that temperature control knobs were to be in place.	F 456	F456 NHC Murfreesboro does maintain all essential mechanical, electrical, and patient care equipment are in safe operating conditions. The missing vent cover on the lid of the tilt skillet was replaced on 9/14/11 by the Dietary Manager. The 2West steam table control knobs were ordered and replaced 9/23/11 by maintenance. In-service to dietary staff will be done 9/28/11 by the Dietary Manager to discuss maintaining all equipment is in safe operating condition. The Dietitian or Dietary Manager will conduct a QA study by using the Food Safety and Sanitation Checklist Monthly x 3 months. This will Be presented to the QA Committee which consist of the Administrator, DON, Medical Director, HIM, Social Worker, Dietitian, and Doctors. The QA committee will review and make any recommendations.	9/28/11
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional	F 514		

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F 514	Continued From page 13 standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to maintain a complete medical record for one (#13) of twenty-six residents reviewed. The findings included: Resident #13 was admitted to the facility on August 30, 2011, with diagnoses including Pubic Fracture, Hyponatremia (low sodium), and History of Fall. Medical record review of the physician's admission orders dated August 30, 2011, revealed "...Fluid restriction 1200ml/day (per day)..." Medical record review of the resident's August 2011, Medication Administration Record (MAR) revealed "...Fluid restriction 1200ml/day..." Medical record review of the resident's September 2011, MAR revealed no entry for the fluid restriction.	F 514	F514 Resident # 13 had an MD order in the computer that was printed and placed on the medical record on 9/14/11 that showed the fluid restriction was discontinued on 8/31/11. All MD orders will be reviewed by the Nurse Manager to ensure they are part of the hard copy chart by 10/1/11. An in-service will be conducted for Licensed nurses by the Nurse Managers by 10/10/11 on the proper process for completing and filing of physician orders. A QA study will be conducted by the DON or Nurse Manager monthly for 3 months by chart review and re-cap reviews. This will be presented to the QA Committee which consist of the Administrator, DON, Medical Director, HIM , Social Worker, Dietitian, and Doctors. The QA committee will review and make recommendations.	10/10/11

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F 514	Continued From page 14	F 514		

Observation on September 13, 2011, at 8:00 a.m., 9:40 a.m., 11:05 a.m., in the resident's room revealed a pitcher filled with ice water, on the over bed table, and within the resident's reach.

Interview on September 13, 2011, 1:15 p.m., with Certified Nurse Assistant (CNA) #4 in the resident's room revealed the CNA had refilled the resident's water pitcher two times since 10:00 a.m., that morning. Continued interview and review of the resident's September 2011, Rehab Patient Group Worksheet with CNA #4 revealed the resident had a fluid restriction of 1200 ml/day.

Interview on September 13, 2011, at 3:47 p.m., in the one west hallway with the Director of Nursing (DON) revealed on August 31, 2011, the physician discontinued the order dated August 30, 2011, for resident #13 to have fluids restricted to 1200 ml/day, and was unaware if the physician's order was in the resident's medical record.

Interview on September 14, 2011, at 10:00 a.m., in the one west hallway with the DON confirmed the physician's order for August 31, 2011, to discontinue resident #13's fluid restriction of 1200 ml/day was not in the resident's medical record, and the medical record was not complete.